ADVANTAGE

*...rising above the service you expect*℠

# State of Indiana
# HMO 2
# BENEFIT SUMMARY

**This summary describes the core benefits of the new alternative plans. Details of any benefits not described in this summary will be administered consistent with the Traditional Plan (generally a 20% co-pay in-network). The HMO options have no out-of-network benefits with the exception of Emergency/Urgent care services. Unless otherwise noted, all services must be provided, authorized or referred by the Member's Primary Care Physician.**

## Annual Out-of-pocket (in-network) $2000 Single/$4000 Family

| PHYSICIAN OFFICE SERVICES | MEMBER COPAY |
|---|---|
| Primary Care Physician Office Visits | $20 Copay per visit |
| Specialist Office Visits | $20 Copay per visit |
| **Services include:**<br>• Routine health exams<br>• Treatment of illness<br>• Laboratory, X-ray and other diagnostic services<br>• Immunizations | |
| Allergy tests (includes serum) | $0 Copay |
| Hearing exams | $0 Copay |

| INPATIENT HOSPITAL SERVICES | MEMBER COPAY |
|---|---|
| Semi-Private room and board, Private room if medically necessary<br>**Services include:**<br>• Operating, recovery room and other special units, including intensive care<br>• Maternity care<br>• Hospital ancillary services including lab, x-ray, EKG and other diagnostic services<br>• Anesthesia, physical therapy and medications<br>• Administration of blood and blood plasma<br>• Physician and Specialist services | $500 Copay per admission |

| OTHER SERVICES | MEMBER COPAY |
|---|---|
| Durable Medical Equipment, Prosthetic Devices, Corrective Appliances and Medical Supplies | 20% Coinsurance |
| Diabetic Supplies | 50% Copay |
| Short-term Therapies: Physical, Speech, or Occupational Therapy, Cardiac Rehabilitation, Pulmonary Rehabilitation | $20 Copay<br>Outpatient – Limited to 60 visits for each distinct condition or episode. |
| Diabetes Self-Management Training | $20 |
| Home Health Services | $20 Copay per day |
| Hospice | $0 Copay |

| OUTPATIENT SERVICES | MEMBER COPAY |
|---|---|
| Outpatient surgery services, related lab and x-ray-services | $250 Copay per visit |

| EMERGENCY SERVICES | MEMBER COPAY |
|---|---|
| Emergency Room (in/out)<br>(Copay waived if admitted) | $75 Copay per visit |
| Urgent Care Center (in/out) | $35 Copay per visit |
| Emergency Ambulance Services<br>(Copay waived if transfer from one acute care inpatient facility to another) | $50 Copay |

| MENTAL HEALTH SERVICES | MEMBER COPAY |
|---|---|
| Inpatient services | $500 Copay per admission |
| Outpatient services | $20 Copay |

| PRESCRIPTION DRUGS | MEMBER COPAY | |
|---|---|---|
| (Retail limited to 30 day supply; Mail Order limited to 90 day supply) | Retail | Mail Order |
| Generic Preferred | $10 Copay | $20 Copay |
| Brand | $20 Copay | $40 Copay |
| Non-Formulary Generic or Brand | 40%Copay | |

| SUBSTANCE ABUSE SERVICES | MEMBER COPAY |
|---|---|
| Inpatient services<br>(Detoxification: two admissions per Lifetime) | $500 Copay |
| Outpatient services | $20 Copay |

| MATERNITY CARE | MEMBER COPAY |
|---|---|
| Care for Pregnancy – Obstetrical care provided before, during, & after delivery. | 10 X PCP OV Copay or 10 X SCP OV Copay |

**Note**: * Mandatory generic when available or member pays difference

Pre-packaged allergy medicines require a prescription

## EXCLUSIONS

- Services and supplies that are not performed, arranged, authorized, or approved in advance by the Covered Person's PCP, except in a emergency situation.
- Services and supplies that are not medically necessary
- Items or devices primarily used for comfort, such as television and telephone while in a hospital.
- Non-skilled care, rest cures, respite care, convalescent care or domiciliary care.
- Physical exams and related expenses, when provided for employment, school, travel, immigration, or insurance purposes.
- Orthodontia and other dental services, except as expressly stated in the policy.
- Cosmetic or reconstructive procedures and any related services or supplies unless deemed medically necessary.
- Services, drugs and supplies for weight loss, diet health or exercise programs, health club dues, or weight reduction clinics. Treatment for exogenous or morbid obesity, including but not limited to, gastric bypass, gastric stapling, gastric banding, or gastric balloon; liposuction or reconstruction surgery unless deemed medically necessary.
- All treatment, procedures, facilities, equipment, drugs, devices, services or supplies that are considered to be Investigational.
- Voluntary termination of pregnancy.
- Treatment of infertility and impotence; including drugs, testing.
- Hearing aids.
- Growth Hormones.
- Over-the-counter drugs.
- Other exclusions as described in the Certificate of Coverage.

## LIMITATIONS

- Members must use the Plan's participating providers. These providers are subject to change from time to time.
- Members must live or work within the Plan's service area to remain covered by the plan.
- Members must select a PCP within a 30 mile radius of their residence.
- Mandatory Generic Substitution is required for all prescription drugs. If the Covered Person or the Covered Person's physician requests a Brand Name prescription drug and a Generic equivalent is available, the Covered Person will pay their applicable Copayment plus the cost difference for the Brand Name Drug.

## COPAYMENTS

- Copayments must be made at the time services are rendered.
- Usual, customary and reasonable charges (UCR) are those commonly charged health service fees within a geographic area as described in the Evidence of Coverage.

## ETHICAL AND RELIGIOUS DIRECTIVES

ADVANTAGE is an institution operated in accordance with The Ethical and Religious Directives for Catholic Health Care Services, as approved by the National Conference of Catholic Bishops. ADVANTAGE shall not be required to provide services that are inconsistent with the medical ethics of the Catholic Church.

**If you have any questions please contact ADVANTAGE Health Solutions at:**
**P.O. Box 80069**
**Indianapolis, Indiana 46280**
**(317) 573-6228 or (800) 553-8933, 7:30 a.m. – 5:30 p.m. (Monday-Friday)**
**TDD: 800-743-3333 (hearing impaired)**

***THIS SUMMARY IS A GENERAL OUTLINE OF COVERED BENEFITS UNDER YOUR PLAN AND DOES NOT INCLUDE ALL THE BENEFITS, LIMITATIONS AND EXCLUSIONS OF THE POLICY. PLEASE SEE THE GROUP POLICY AND/OR CERTIFICATE OF COVERAGE FOR SPECIFIC DETAILS.***

**VISIT OUR WEBSITE AT** WWW.ADVANTAGEPLAN.COM